

33 Princess Street, Suite #206
Leamington, Ontario N8H 5C5
Phone: (519) 398-8598
Fax: (519) 398-8893



Dr. Lucas Szczepanik B.Sc., D.C.

CONFIDENTIAL PATIENT HEALTH HISTORY

Date: _____

Patient Information

Name: _____ Sex: Female Male

Address: _____

City: _____ Prov.: Ontario Postal Code: _____

H. Phone: (519) _____ W. Phone: (519) _____ Ext.: _____

Date of Birth: _____ / _____ / _____ Age: _____ Med.Dr: _____
 yr mm dd

Spouse's name: _____ Referred By: _____

Contact Person (if different): _____ Phone: _____

Names & ages of children: _____

Student: Retired: Employer: _____ Occupation: _____

Is your condition due to:

A work related injury? Yes No If yes: What is your SIN number? _____

What is the date of accident? _____

An automobile accident? Yes No If yes, what is the date of accident? _____

Have you ever received chiropractic care? Yes No If yes:

Who: _____ When: _____

Would you like to be added to our email list for our informational newsletter? Yes No

If yes, what is your email address? _____

Insurance Information

Do you have Green Shield Canada Insurance Coverage? If Yes:

Policy No.: _____ Employer _____ Coverage _____

Name as it appears on Benefit Card _____

I give authorization to Active Body Chiropractic Clinic, Dr. Lucas Szczepanik, to submit personal information to my insurance company necessary for claims adjudication, and for Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information. I hereby authorize all future payments to be made, directly to Dr. Lucas Szczepanik, Active Body Chiropractic Clinic.

Signature _____

Do you have other extended health coverage? _____

Active Body Chiropractic Clinic • Dr. Lucas Szczepanik B.Sc., D.C. • 33 Princess Street, #206 Leamington, Ontario N8H 5C5

Patient Name: _____

About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are helping to block your body's innate ability to be well and healthy.

Symptoms and Ill Health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

Present reason for consulting our office:

- Correction and prevention of existing problem?
- Maximizing personal and / or family health potential?

If you have a specific chief complaint, please describe briefly. *If not, please go to next page.*

How and when did this problem start? _____

Does the pain radiate or travel anywhere else? _____

Is the problem... constant intermittent worse with movement
Is condition worse... in the A.M. in the P.M. no change

Is the condition interfering with...
 sleep work routine other _____

Is condition getting progressively worse? Yes No

Pain is... sharp dull throbbing
 aching shooting nagging other _____

What aggravates your condition / pain? _____

What relieves your condition / pain? _____

If your condition was treated in the past, please describe treatment and results. _____

Have you had x-rays taken of this area? Yes No

Secondary complaints? _____

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Patient Name:

File No.:

Health History

Have you ever or do you presently suffer from any of the following symptoms?
Please list present treatment and include any medications being taken.

Headaches Ears ring Stiff/painful neck Nervousness

Depression Tension Fatigue Sleep problems

Chest Pains Heart/lung trouble Digestive disorders Menstrual
problems

Numbness or pins Numbness or pins Cold feet/hands Arthritis -
where?
& needles in arms & needles in legs

If none please specify.

Are there any other medication or treatment you are receiving? (include birth control pills)

List any surgeries and include when? _____

What if any side effects have you experienced from your medications or surgery? _____

Do you suffer from or is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	High BP	Other
Self ☺ _____	☺	☺	☺	☺	☺	☺	☺
Mother's Side ☺ _____	☺	☺	☺	☺	☺	☺	☺
Father's Side ☺ _____	☺	☺	☺	☺	☺	☺	☺

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Patient Name: _____

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Events and habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

Yes	No		Patient's Comments
☺	☺	1. PREGNANCY: Did your mother....	
☺	☺	Experience any falls /injuries during pregnancy?	_____
☺	☺	Experience distress during delivery?	_____
☺	☺	Experience any prolonged illness?	_____
☺	☺	2. GROWING YEARS	
☺	☺	Were you taught how to care for your spine?	_____
☺	☺	Any notable falls?	_____
☺	☺	Any significant childhood injuries or illnesses?	_____
☺	☺	Any childhood surgeries	_____
☺	☺	Any prolonged medications?	_____
☺	☺	Mental or physical abuse?	_____
☺	☺	3. ADULTHOOD	
☺	☺	Ever in a motor vehicle accident?	_____
		If yes, When?	_____
		Any trauma or symptoms?	_____
☺	☺	Any notable falls or injuries as an adult?	_____

<input type="checkbox"/>	<input type="checkbox"/>	Any bone fractures / surgery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobby or sports injuries?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Smoke?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol?	_____
		<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Sporadically	
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____
		<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Sporadically	
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	Proper posture?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eat as healthy as you think you should?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you or have ever been overweight?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Repetitive lifting / bending?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Continuous sitting / standing?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Extensive computer work?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems?	_____
		Sleep posture - <input type="checkbox"/> side <input type="checkbox"/> back <input type="checkbox"/> stomach	_____



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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed Consent to Chiropractic Treatment FORM - L

CCPA09.08

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Date Signed

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Witness of Signature

Dates Reviewed

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____